NC DIVISION MH/DD/SAS
FY 2009/2010 CAP-MR/DD SERVICES AUDIT

PROVIDER NAME:			**AUDIT DATE:**	
PROVIDER #:			**NAME:**	
CONTROL #:			**SERVICE TYPE:**	
MEDICAID #:			**PROCEDURE CODE:**	
DOB/AGE:			**SERVICE DATE:**	
RECORD #:	**WAIVER:**		**UNITS PAID:**	
RATING CODES:	**O = No 2 = partially met 4 = Yes**	**6 = No service note 7 = Unable to identify service provider**	**8 = Repaid 9 = NA**	**RATING**

AUTHORIZATIONS/CONTINUED NEED REVIEW/PLAN OF CARE (Use rating of "4" or "0" for Q 1-3		
1. a. Is an authorization in place covering this date of service? b. If NO, list dates: FROM_____TO_____		
2. a. Is the provider enrolled with Medicaid to deliver this specific service? b. If NO, list dates: FROM _____TO_____		
3. a. Is the date of service covered by a current PCP? b. If NO, list dates: FROM_____TO_____		
SERVICE DOCUMENTATION (Use Likert Scale See Guidelines): (Use rating of "4", "2" or "0" for Q 4-7 or 6, 8, or 9 as applicable)		
4. Does the service note(s) relate to goals listed in the PCP?		
5. Does the documentation reflect interventions/treatment for the duration of service?		
6. Does the service note reflect assessment of progress toward goals?		
7. Is the documentation initialed and signed within the designated time frame by the person who delivered the service?		
8. Do the units documented match units paid? If no, write number of units documented: _____		
QUALIFICATIONS/SUPERVISION/RECORD CHECKS: (Use rating of "4" or "0" for Q 9 -12—or 7, 8 or 9 as applicable)		
9. Is there documentation that the staff is qualified to provide the service billed? a. Did the individual have Alternative to Restrictive Intervention training prior to date of service? b. Did the individual meet all other requirements as listed on the Qualifications Checklist? c. If "a" or "b" is NO, list dates: FROM:_____ TO:_____	**a. b.**	
10. a. Is an individualized supervision plan in place for paraprofessional and AP staff? b. Has the plan been implemented? c. If "a" or "b" is NO, list dates: FROM:_____ TO:_____	**a. b.**	
11. Did the provider agency conduct a criminal background check on the staff person(s) who provided this service? a. If NO, list dates: FROM:_____ TO:_____		
12. Did the provider agency complete a Health Care Personnel Registry check prior to this date of service? a. If NO, list dates: FROM:_____ TO:_____		

COMMENTS:

AUDITOR:	**LME:**